

GEOFFREY E. LEBER, M.D., P.C.
AESTHETIC PLASTIC SURGERY AND MEDSPA
PATIENT REGISTRATION FORM

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

BIRTHDATE: _____ AGE: _____

EMPLOYER: _____

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

HOW WERE YOU REFERRED TO OUR OFFICE?

PROCEDURES OR TREATMENTS OF INTEREST?

TIME FRAME FOR SURGERY?

WOULD YOU LIKE TO BE NOTIFIED OF UPCOMING SPECIALS? _____

IN CASE OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

PATIENT/PARENT/GAURDIAN SIGNATURE:

_____ DATE: _____

Geoffrey E. Leber, M.D., P.C.
Aesthetic & Reconstructive Plastic Surgery

RELEASE OF YOUR HEALTH INFORMATION

Who may receive information regarding your Protected Health Information? (Check all that apply)

Spouse Name and Birthdate: _____

Children Names and Birthdates: _____

Significant Other/Friend Name and Birthdate: _____

May we leave messages regarding appointments or other health information on your answering machine? yes no

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I have been presented with a copy of Dr. Geoffrey Leber's "*Notice of Privacy Practices*" policy, detailing how my information may be used and disclosed as permitted under Federal and State Law. I understand the contents of the Notice, and I place no additional restriction(s) concerning my personal medical information. This authorization may be revoked in writing by me at any time.

Date: _____ Signature: _____

AUTHORIZATION, ASSIGNMENT AND RELEASE

I acknowledge that the information supplied on this registration form is true and correct and that it has been furnished to this office with full understanding that I am liable for payment of all services rendered regardless of insurance coverage. If my account is referred to a collection agency, I agree to pay collection expenses including attorney's fees. Confidentiality rights shall be waived if collection becomes necessary. I hereby authorize and request that payments under my insurance plans be made directly to Geoffrey E. Leber, M.D. for any services furnished to me. I also authorize the release of any information required to process insurance claims, including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

Date: _____ Patient/Parent/Guardian Signature: _____

MEDICAL/SURGICAL HISTORY

Patient Name:

Today's Date:

Patient No.:

Surgery Date:

Surgeon Name: **Geoffrey Evans Leber, M.D.**

Procedures:

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age:	Height:	Weight:	Occupation:
Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).			
Medication(s):	Amount	Frequency	
List all drug allergies:			
Have you ever used (circle): LSD/speed/cocaine/marijuana? Never			
Are you a smoker? YES/NO Ex-Smoker YES/NO Non-Smoker YES/NO			
How much are (were) you smoking?		How long?	Quit how long ago?
How much alcohol do you drink?		Caffeine?	
Please circle all of the following medical conditions you now have or have had in the past: bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / any other serious illness or injury / None of the above			
Is there any possibility that you may be pregnant at this time? YES/NO			
List all surgeries that you have had (include plastic surgery):			Date:
Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers? YES/NO			
Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/None			
Have you ever seen a cardiologist? YES/NO Physician Name:			
Date of last EKG:			

Patient's Signature:

Date: